

**CENTER FOR DISEASE PREVENTION & EPIDEMIOLOGY • OREGON HEALTH DIVISION**

**INFLUENZA VACCINE EDUCATION AND PRIORITIZATION PLAN 2001-2002**

**L**AST YEAR, 6- to 8-week delays in the production of influenza vaccine in the U.S. limited the amount that was available during the traditional peak flu vaccination season; by the end of October, fewer than 28 million doses were available, compared with more than 70 million doses available by that time in 1999. Although the eventual production of 78 million doses was about the same as in 1999, the delays caused temporary price spikes and left some high-risk persons, who otherwise would have been vaccinated, to fend for themselves against the blitzkatarrh with unarmed immune systems.<sup>1</sup>

For the 2001–2002 season, forecasters predict an eventually increased supply of flu vaccine—83.7 million doses. However, only 53.4 million (64%) of these will be available by the end of October. Hence, the need once again to set priorities for vaccination during the early fall. This issue of the *CD Summary* details the Oregon plan, which is intended for all providers of influenza vaccine in the state. It is based on the principle that influenza vaccination providers should actively seek out and give highest priority to persons who are most likely to experience complications (including death) from influenza. To minimize

morbidity and mortality from influenza, cooperation is needed from all communities and providers of vaccination services.

The activities and time line below are based on our understanding that there will be enough flu vaccine to immunize all individuals in high-risk categories 1 and 2 in September and October. Vaccination of individuals in risk category 3 should commence in November and continue through January. (See risk categories defined, *verso*.) In the unlikely event that an extremely severe vaccine shortage were to develop, vaccine should be reserved for individuals in risk category 1.

**COMMUNICATION AND COLLABORATION ARE KEY**

In anticipation of flu vaccine delays, collaboration among community providers is essential to ensure that vaccine is shared with those providers who have inadequate supplies to cover all persons in risk categories 1 and 2. Each community should have a strategy for sharing vaccine and a lead agency serving as the local public health authority responsible for coordinating these efforts. The local public health authority is responsible for:

- Determining if all clinics and/or facilities in their area have adequate vaccine supplies to vaccinate persons in categories 1 and 2, and
- Attempting to locate additional resources in the community (e.g., vaccine, clinic services, etc.) for any clinic or facility that does not have sufficient vaccine to meet demand.

The responsibilities of medical clinics, long-term-care facilities, and others providing vaccination services:

- If you do not have sufficient vaccine for persons in priority categories 1 and 2 and are part of a health system, contact your parent company to determine if you can acquire vaccine from within the health system, and
- Contact the local health department in your area if you do not have sufficient vaccine for persons in priority categories 1 and 2 *or* if you have vaccine remaining after vaccinating persons in categories 1 and 2.

**KEY MESSAGES FOR INFLUENZA IMMUNIZATION PROVIDERS**

- Give priority to vaccinating persons who will experience serious morbidity and death if they develop influenza.
- Remember, as long as influenza virus is still circulating, it is *never* too late to get vaccinated! Continue immunizing through January.

**Timeline and Activities of Flu Vaccination Efforts in 2001–02**  
Endorsed by the Oregon Health Division and the Southwest Washington Health District

Time Period	Activity and Target Group
Beginning when vaccine is available but no earlier than September, and continuing through January.	<b>Clinic-based and other approaches that target persons at high-risk:</b> As soon as vaccine is available but no earlier than September, private medical clinics should start routine vaccination of high-risk persons, their direct care givers and healthcare workers (priority categories 1 and 2) when such persons are seen at their primary medical clinic for routine care, are hospitalized, or seen in home care. Programs that provide vaccine to high-risk persons in long-term-care facilities should reserve vaccine for these residents, and vaccinate them in November due to their shorter term immunity.
Beginning October 1, in close coordination with the local public health authority, and continuing through January.	<b>Community- or retail-based approaches that target high-risk persons:</b> Vaccinate ONLY high-risk persons, their direct care givers and healthcare workers (priority categories 1 and 2) in retail-based and other community-based settings (e.g., churches, public health agencies, senior centers) provided adequate vaccine is available, screening is appropriate, and commencement of clinics is in close coordination with the local public health authority. These clinics should only be run once the local public health authority is assured that vaccine is available to all local medical providers of high-risk clients.
Beginning November 1, and continuing through January.	<b>Other community- or retail-based clinics:</b> Vaccinate the general, otherwise healthy, public. <b>Worksite-based approaches:</b> Begin vaccination campaigns directed to employer groups that serve predominantly healthy persons <65 years.



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- Remember to administer pneumococcal vaccine (along with fluvaccine) to eligible high-risk persons.

#### **BEST PRACTICES FOR INFLUENZA IMMUNIZATION CAMPAIGNS**

- Share information and vaccine with other providers serving high-risk clients. Refer clients to other locations as appropriate.
- Collaborate with community groups representing the elderly or those with chronic diseases to promote immunizations.
- Schedule and publicize special “senior clinics” when only elderly or other high-risk patients will be accepted. Best to schedule these during daytime hours to avoid competition with younger, healthier clients.
- Promote the campaign with public-service announcements stressing a commitment to serve first the high-risk population and asking healthy people to cooperate by waiting for additional vaccine to become available. Include up-to-date information about expected vaccine availability.
- Post visibly the criteria for identifying high-risk individuals to enable prospective vaccinees to determine their risk status before waiting in line for vaccination.
- Offer incentives for non-high-risk clients who accept a “rain check” to return at a later date for their shots.
- Establish “express lanes” for elderly and high-risk patients to reduce the amount of time they have to stand in line.
- Keep clients and customers informed about the need to vaccinate those at high-risk first and assure others of the future availability of vaccine.

#### **PRIORITY CATEGORIES**

##### **Category 1**

Groups at highest risk for influenza-related complications, including:

- Persons 65 years of age or older.
- Residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions.
- Adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma.
- Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression including immunosuppression caused by medications).
- Children and teenagers (age 6 months to 18 years) who are receiving long-term aspirin therapy that might put them at risk for developing Reye syndrome after influenza.
- Women who will be in the second or third trimester of pregnancy during the influenza season.

##### **Category 2**

Persons having closest contact with persons in category 1, including:

- Household members (including children) of high-risk persons in category 1.
- Physicians, nurses, and other staff in hospital and outpatient settings who provide direct patient care.
- Employees of nursing homes and chronic-care facilities who have direct contact with patients or residents.

- Employees of assisted-living and other residences for persons in high-risk groups who provide direct care.
- Providers of home care to people at high risk (e.g., visiting nurses and volunteer workers).
- Emergency medical responders.

##### **Category 3**

Otherwise healthy persons age 6 months and older who wish to reduce their likelihood of becoming ill with influenza, such as:

- All adults 50–64 years of age.
- Students and other persons in institutional settings (e.g., college students in dormitories).
- Employees of health-care facilities who do not provide direct patient care.
- Persons who provide essential community services.
- Healthy persons in the workplace.
- Children and workers in day care settings.
- Others.

In the event of a severe vaccine delay or shortage, the Oregon Health Division has the authority to declare a vaccine shortage emergency, and thereafter to levy civil penalties upon providers not abiding by the Timeline and Activities (ORS 433.001–433.045). These guidelines will be updated as new information becomes available. Influenza updates are posted on OHD’s web site (<http://www.oshd.org/acd/docs/influenza.htm>). To update listings of flu clinics and find out about other flu clinics in Oregon, please call Safenet at 1/800/SAFENET. SafeNet will only include sites that abide by this plan and commit to vaccinate high-risk individuals on a priority basis. For information on flu clinics in southwest Washington, visit <http://www.swwhd.wa.gov>. Please visit the OHD web site for additional information: <http://www.ohd.hr.state.or.us>.

#### **REFERENCE**

- US General Accounting Office. Flu vaccine: Steps are needed to better prepare (*sic*) for possible future shortages (GAO-01-786T). Available at <<http://www.gao.gov/new.items/d01786t.pdf>>. Accessed July 31, 2001.